

471-000-6 Instructions for Completing Form DM-5R. "Disability Report"

Use: Central Office staff use Form DM-5R, "Disability Report," to –

1. Report the decision regarding -
 - a. Disability/incapacity of applicants for Assistance to the Disabled, the State Disability Program, ADC-I, and LIEAP (cooling assistance); and
 - b. Review of disability/incapacity for clients of Assistance to the Disabled and the State Disability Program; and
2. Recommend treatment and/or services appropriate for the individual applicant.

Number Prepared: The State Review Team (SRT) physician and the social worker complete three copies of Form DM-5R.

Completion: Enter identifying information and complete Sections I through IV as appropriate.

Section I: Check the appropriate box to indicate the decision of the SRT on the referral.

- A. Check this box if the medical and/or social information submitted is insufficient for the SRT to determine disability, incapacity, or need for cooling assistance. Local office staff should obtain and submit the additional information requested.
- B. Check this box if the client's disability/incapacity is denied, and indicate the basis of the denial by checking
 - Box 1, if the client is not disabled;
 - Box 2, if the client is not incapacitated; or
 - Box 3, if the client's medical condition does not require cooling assistance.
- C. Check this box if the client's disability/incapacity is approved, and check the program under item #1 for which program approval is being given. Check the appropriate box under item #2 to establish the type of disability/incapacity. Under item #3, check box 'a' if the disability is permanent and/or no review is requested; check box 'b' if the disability/incapacity is temporary and enter the number of months for which approval is given and the date the review of disability/incapacity is due.

Section II: Check the appropriate boxes to indicate the State Review Team recommendations regarding a definite plan of service for the applicant.

Section III: Use this section for supplemental explanation and additional information. Enter the medical effective date here if a disability determination has been requested for a month(s) before the month of review.

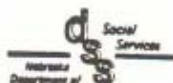
Section IV: Enter the diagnosis code. The diagnosis code must also be entered in Field 33 on Form PDS-110.

Signatures: The State Review Team physician and social worker shall sign the Form DM-5R.

Date: Enter the date on which the form is completed.

Distribution: The State Review Team sends the original and one copy of Form DM-5R to the appropriate local office and retains one copy in the Central Office. For ADC-I approvals and cooling assistance approvals, the State Review Team nurse may sign for the physician.

Retention: Form DM-5R is remained permanently.



DISABILITY REPORT

FORM
DM-5R

Name	Local Office
Birthdate	Social Security Number

Medical and social information submitted has been considered in terms of the established definitions set forth in applicable Department of Social Services Regulations.

I. Decision

A. ☐ Insufficient current medical information—additional information should be submitted _____

B. ☐ Denied

- | | |
|---|--|
| 1. <input type="checkbox"/> Not Disabled | 2. <input type="checkbox"/> Not incapacitated |
| a. <input type="checkbox"/> Due to lack of severity | |
| b. <input type="checkbox"/> Due to lack of duration | 3. <input type="checkbox"/> Medical condition does not require cooling |

C. ☐ Approved

- | | |
|--|---|
| 1. Program | |
| a. <input type="checkbox"/> Disabled - AABD/MA (Program 3) | e. <input type="checkbox"/> Incapacitated (ADC/MA Program 4) |
| b. <input type="checkbox"/> Disabled SDP/MA (Program 7) | d. <input type="checkbox"/> Medical condition requires cooling (NLIEAP) |

2. The disability/incapacity is considered:

- a. ☐ Physical b. ☐ Mental c. ☐ Physical and Mental

3. a. ☐ Disability is Permanent and review is not requested.

- b. ☐ Disability/incapacity is TEMPORARY for period of _____
- Review is to be received BEFORE _____

II. A definite plan of follow-up is of major importance to this disabled/incapacitated client; it is recommended service be directed toward:

- | | |
|---|--|
| <input type="checkbox"/> Training for employment | <input type="checkbox"/> Medical, surgical, and psychiatric treatment as needed. |
| <input type="checkbox"/> Training for self-care | <input type="checkbox"/> Psychological/psychiatric evaluation. |
| <input type="checkbox"/> Physiotherapy and physical restoration | |
| <input type="checkbox"/> Mental and/or occupational therapy | <input type="checkbox"/> _____ specialist evaluation. |

III. Comments _____

IV. Diagnosis Code:

SIGN HERE	_____	_____
	Medical Consultant	Date
SIGN HERE	_____	_____
	Worker	Date